HIPAA COMPLIANT AUTHORIZATION FORM
FOR THE RELEASE OF EDUCATION RECORDS
PURSUANT TO 45 C.F.R. § 164.508

Name or specific identification of the person(s), or class of person, authorized to make the requested disclosure:

_____

Student Name: _____ A/K/A _____
Date of Birth: _____ Social Security Number: _____
Address: _____

I authorize disclosure of all protected medical or other confidential information for the purpose of review and evaluation in connection with a legal claim. I expressly request that all covered entities HIPAA identified above disclose full and complete protected medical information spanning the time period of _____ to present including the following:

- All attendance records, teachers' notes and reports and disciplinary records.
- All guidance counseling records, psychology records, drug and/or alcohol counseling records.
- All medical/school nurse/infirmary records.
- All medical records, including inpatient, outpatient and emergency room treatment, all clinical charts, reports, documents, correspondence, test results, statements questionnaires/histories, office and doctor's handwritten notes, and records received by other physicians.
- All autopsy, laboratory, histology, cytology, pathology, radiology, CT Scan, MRI, echocardiogram and cardiac catheterization reports.
- All radiology films, mammograms, myelograms, CR scans, photographs, bones scans, pathology/cytology/histology/autopsy/immunohistochemistry specimens, cardiac catheterization videos/CDs/films/reels, and echocardiogram videos.
- All pharmacy/prescription records include NDC numbers and drug information handouts/monographs.
- All billing records including all statements, itemized bills, and insurance records.

Information about alcohol/substance abuse and HIV/AIDS may be disclosed as follows: (check all that apply)
__X__ Yes, disclose HIV/AIDS information ____ No, do NOT disclose HIV/Aids information
__X__ Yes, disclose alcohol/substance abuse information ____ No, do NOT disclose alcohol/substance abuse information

I authorize you to release the protected health information to:

Defendant(s) Counsel:

- Baker, Donelson, Bearman, Caldwell & Berkowitz, P.C., Post Office Box 14167, Jackson, MS 39236 (Counsel for Cardinal Health 409, Inc. n/k/a Catalent Pharma Solutions, Inc.) and Pietragallo, Gordon, Alfano, Bosick & Raspanti, LLP, One Oxford Center, 38th Floor, Pittsburgh, PA 15219 (Counsel for the Mylan Defendants).

- Ulmer & Berne, LLP, 600 Vine Street, Suite 2800, Cincinnati, OH 45202-2409 (Counsel for the Barr Defendants).

- Duane Morris, LLP, 30 South 17th Street, Philadelphia, PA, 19103-4196 (Counsel for the Ranbaxy Defendants).

- I acknowledge the right to revoke this authorization by writing to the above counsel at the above address. However, I understand that any actions already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.
- I acknowledge the potential for information disclosed pursuant to this authorization to be subject to redisclosure by the recipient and no longer be protected under 45 C.F.R. § 164.508.
- I acknowledge the right to inspect the material to be released.
- I understand that the covered entity to whom this authorization is directed may not condition treatment, payment, enrollment or eligibility benefits on whether or not I sign the authorization.
- Any facsimile, copy or photocopy of the authorization shall authorize you to release the records herein.
- This authorization expires two years from the date below.

Signature: _____ Date: _____
Relationship to person who is the subject of the records:
Self: ___X___ Other: _____
Describe Authority